STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155525	A. BUILDING _____ B. WING _____	C 08/04/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHADY NOOK CARE CENTER	36 VALLEY DR LAWRENCEBURG, IN 47025

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS This visit was for the Investigation of Complaint IN00205513. Complaint IN00205513 - Substantiated. No deficiencies related to the allegations are cited. Survey dates: August 3 and 4, 2016 Facility number: 000304 Provider number: 155525 AIM number: 100266810 Census bed type: SNF/NF: 64 Total: 64 Census payor type: Medicare: 6 Medicaid: 48 Other: 10 Total: 64 Sample: 3 Shady Nook Care Center was found to be in compliance with 42 CFR Part 483, Subpart B and 410 IAC 16.2 - 3.1 in regard to the Investigation of Complaint IN00205513. QR was completed by 99993 on 08/05/16.	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE